


Speech-Language Pathology and Audiology Board

1422 Howe Avenue, Suite 3, Sacramento, CA 95825
 Telephone: (916) 263-2666 / Fax: (916) 263-2668
 www.slpab.ca.gov



TERMINATION OF SUPERVISION

Division 13.4 of Title 16, California Code of Regulations Section 1399.170.18 requires that at the time of termination of supervision, the supervisor shall submit this original signed form within fourteen days of the termination of supervision.

_____ Speech-Language Pathology Assistant's Name	_____ SPA Number
_____ Supervisor's Name	_____ License or SSN Number

I, _____, certify that I supervised _____, in performing the duties and functions of a speech-language pathology assistant in accordance with Section 1399.170.15 of the California Code of Regulations from _____ to _____.

I declare under penalty of perjury under the laws of the State of California that I have read and understand the foregoing and the information submitted on this form is true and correct.

_____ Printed Name of Qualified Supervisor	_____ Signature of Qualified Supervisor	_____ Date
_____ Mailing Address: No. & Street	_____ City	_____ State
_____ Qualified Supervisor's Daytime Telephone Number		

The **original** of this form must be mailed to:

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